MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (64c)

CERTIFICATE OF DEATH

Reg. Dist. No. 3-33

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Worcester

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Balto

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 5 E. Biddle St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Gertrude Abell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George H. Abell

6.(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): March 10, 1910.

8. AGE: Years: 36 Months: 5 Days: 27 If less than one day: ... hrs. ... min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

MOTHER FATHER

12. Name: M. Grant Gill

13. Birthplace: Baltimore, Md.

MOTHER

14. Maiden name: Rebecca Cisler

15. Birthplace: Baltimore, Md.

16. Informant: Mrs. Madeleine G. Gill

Address: Ocean City, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 9/19/46 (month) (day) (year)

Cemetery or crematory: Guardenia

Location: Baltimore, Md.

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md.

19. 9/18, 1946 Harriet E. Johnson Local Registrar (Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 17, 1946, at 4:40 a.m. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: Coma, Shock & Hemorrhage Liver — DURATION: 4 days

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: Sept 13'46

Where did injury occur? (City or town) Near Ocean City (County) Wor (State) Md

Injured at home, farm, industry, public place (where?): Near Ocean City

Means of injury: Bullet wound Injured at work? No

23. SIGNATURE: John L. Riley M.D. Med Exam M. D. or other

Address: Ocean City Md Date signed: 9/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09388

Reg. Dist. No. 339

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Aug. 21, 1946

Hospital, institution, or street address where death occurred:
Eastern Shore Tuberculosis Sanatorium

How long in hospital or institution? Since Aug. 21, 1946

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Marion Station, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ADAMS, John Irving

3.(b) Social Security Number: 214-03-5829

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: Gloria Somers

6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): Dec. 9, 1917

8. AGE: Years	Months	Days	If less than one day
28	9	21	..... hrs. ..... min.

9. Birthplace: Marion Station, Maryland
(Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business

FATHER — 12. Name: John T. Adams

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Lottie Green

MOTHER — 15. Birthplace: Maryland

16. Informant: self

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 3, 1946 (month) (day) (year)

Cemetery or crematory: Sunny Ridge Cemetery

Location: R F D Crisfield, Maryland

18. Funeral director: H. Harvey Bradshaw

Address: Crisfield, Maryland

10/2/46 19..... (Date rec'd by registrar)

Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 30 19 46, at 11:30p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/21/46 19..... to 9/30/46 19.....

and that I last saw h... im alive on 9/29/46 19.....

Immediate cause of death	DURATION
Pulmonary tuberculosis	3 yr 9 month
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Lu L. Laury, M.D. M. D. or other

Address: Salisbury, Maryland Date signed: 10/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

0938

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH: Wicomico Co.

County

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 2 yrs

Hospital, Institution, or street address where death occurred: RD #1.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. #1.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William H. Adkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower.

6.(b) Name of husband or wife: Savenia adkins

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Dec. 1-1861

8. AGE: Years: 84 Months: 9 Days: 20 If less than one day: hrs. min.

9. Birthplace: R.D. Salisbury Md. (Town, county, and state)

10. Usual occupation: retired

11. Industry or business: Farmer

FATHER 12. Name: Barnella adkins

13. Birthplace: Worcester Co. Md.

MOTHER 14. Maiden name: Savenia Hillman

15. Birthplace: Wic. Co. Md

16. Informant: Mrs. Wilmer E. adkins

Address: R.D. #1. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept. 23-46 (month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Md.

18. Funeral director: Holloway & G. Walter R. Holloway

Address: Salisbury Md.

19. 9/23/46 (Date rec'd by registrar) Harold E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 21st 1946, at 11 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~to~~ [illegible] 19 [illegible] 19 and that I last saw deceased alive on ~~Sept.~~ [illegible] 19

Immediate cause of death	DURATION
Coronary occlusion	1 day
Due to: Arteriosclerosis senile	18 mos.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Nature of injury: Injured at work?

23. SIGNATURE: La Rademacher M.D. Deputy Med Examiner

M. D. or other

Address: Salisbury Md. Date signed: 9/22/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

09390

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. Peninsula Gen Hospital

(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Copes Andrew

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	married

6.(b) Name of husband or wife Jennie Copes (Don't know maiden name)

6.(c) If alive, give age yes years

7. Birth date of deceased (mo., day, yr.) about 1883

8. AGE: Years	Months	Days	If less than one day
about 63	-	-	hrs. min.

9. Birthplace Salem md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Same as above

FATHER 12. Name George Copes

FATHER 13. Birthplace Salem

MOTHER 14. Maiden name unknown

MOTHER 15. Birthplace unknown

16. Informant Mrs Jennie Copes

Address Salem md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 8-46 (month) (day) (year)

Cemetery or crematory Wesley Tompkins

Location near Parsley, Md

18. Funeral director James R Stewart

Address Salisbury Md

19. 9/6/1946 Received by Registrar Harriet E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 5 1946, at 2 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 31, 1946 to Sept 5, 1946 and that I last saw h. alive on Sept 4, 1946.

	DURATION
Immediate cause of death: Pyloric obstruction	7-14 days
Due to: Gastric Carcinoma	2
Due to:	
Other conditions: Cachexia, anemia	7 days

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William B. Long M. D.

M. D. or other

Address 503 N. Division St. Date signed Sept 5, 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

09391

CERTIFICATE OF DEATH

Reg. Dist. No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH: Wicomico

County: Wicomico

City or town: Pittsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: R.D. #1.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State: Md. County: Wicomico

City or town: Pittsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.D. #1.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charlie Banker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14 1868

8. AGE: Years 78 | Months 6 | Days 9 | If less than one day: hrs. min.

9. Birthplace: Worcester Co. Md. (Town, county, and state)

10. Usual occupation: Farm Laborer

11. Industry or business

MOTHER FATHER

12. Name: (No Record) Banker

13. Birthplace: Worcester Co. Md.

14. Maiden name: (No. Record) Banker

15. Birthplace: Worcester Co. Md.

16. Informant: M. J. Samuel Carey

Address: 415 Camden ave, Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 25-46 (Month) (Day) (Year)

Cemetery or crematory: Md. Bethesda Church Cem.

Location: R.D. #1. Pittsville Md.

18. Funeral director: Holloway & C. Walter R. Holloway

Address: Salisbury Maryland.

19. 9/25/46 (Date rec'd by registrar) Harriet E. Johnson Registrar Dead

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 23rd 1946, at 7. P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1944, to Sept 23 1946 and that I last saw him alive on Sept 23 1946

	DURATION
Immediate cause of death: Acute dilatation of heart	few mnts
Due to: Prolonged attack of Tachycardia	2 yrs
Due to: Chronic Myocarditis	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. H. Lynch M. D. or other

Address: Pittsville Md. Date signed 9/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

09392

Reg. Diat. No. 330

1. PLACE OF DEATH:
County: Wicomico
City or town: Mardela Md R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 weeks
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wic
City or town: Mardela Md. R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary L. Beach

3. (b) Social Security Number:

4. Sex: F
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6. (b) Name of husband or wife: Levin T. Beach
6. (c) If alive, give age: 73 years
7. Birth date of deceased (mo., day, yr.): July 10 1875
8. AGE: Years: 71 Months: 2 Days: 13 If less than one day: hrs. min.
9. Birthplace: Mardela Wic. Md. (Town, county, and state)
10. Usual occupation: House work
11. Industry or business:
FATHER 12. Name: Cornelius W. English
13. Birthplace: Md
MOTHER 14. Maiden name: Louisa H. Wright
15. Birthplace: Md.
16. Informant: Levin T. Beach
Address: Mardela, Md R.D.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-25-1946 (month) (day) (year)
Cemetery or crematory: Family Grave Yard
Location: Near Mardela Md
16. Funeral director: Graveson Bros
Address: Sharptown
19. 9/25/46 (Date rec'd by registrar) 19 W. H. Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 9-23 1946, at 10 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1946, to Sept 23 1946
and that I last saw h[illegible] alive on Sept 22 1946
Immediate cause of death: Coma

	DURATION
	4 days
Due to: Ruptured cerebral Hemorrhage	last 4 yrs
Due to: Hypertension & arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Lynch M. D. or other
Address: Parsonsburg Md Date signed 9/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

09393

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 hrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Somerset
City or town Sheetstown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Coda Beauchamp

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Unknown 1858

8. AGE: Years 88 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name Unknown
13. Birthplace "

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Mrs. Mary A. Duncan
Address Sheetstown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 23, 1946 (month) (day) (year)
Cemetery or crematory Quinton
Location Pocomoke Rural

18. Funeral director Henry H. Watson
Address Pocomoke City, Md.

19. 9/23/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 22 1946, at 10:30 A.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1 1946, to Sept 22 1946 and that I last saw h.. alive on Sept 15 1946

	DURATION
Immediate cause of death Uraemia and Def. Nut. 2 wks	
Due to Acute Myocardiolysis	Yrs
Due to Chronic Nut. Nephritis	
Other conditions Senile Arteriosclerosis	Yrs

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Guy D. Quillin M.D.
M. D. or other
Address Marion Station Date signed Sept 23 1946

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

09394

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Shaystown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME John Phillip Bennett

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife Emily Willing Bennett

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) March 26, 1874

8. AGE: Years 72 | Months 5 mos. | Days 7 days | If less than one day ... hrs. ... min.

9. Birthplace Mardela Springs, Maryland
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Merchant

FATHER 12. Name William Bennett

13. Birthplace Mardela Springs, Md.

MOTHER 14. Maiden name Anna Marble Cook

15. Birthplace

16. Informant Mr. Harry O. Bennett

Address Mardela Springs, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 9-6-46 (month) (day) (year)

Cemetery or crematory Mardela Cemetery

Location Mardela, Md.

18. Funeral director David K. Messick

Address Hebron, Md.

19. 9/9 1946 (Date rec'd by registrar) Harriet E. Johnson Deputy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2, 1946, at 10 15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1941 to Sept 2 1946, and that I last saw h... alive on Sept 1 1946.

	DURATION
Immediate cause of death: Bronco Pneumonia	5 days
Due to: Acute gangrenous appendicitis Ruptured	2 days
Due to:	
Other conditions: Chronic Nephritis	3

(Include pregnancy within 3 months of death)

Major findings of operations: Acute gang appendicitis Ruptured Date of op. Sept 2 1946

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M.D. M. D. or other

Address Salisbury Md. Date signed 9/3/46

Dr. Wanner

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (a)

CERTIFICATE OF DEATH

09395

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico

County ..... Salisbury

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ..... Lifetime

Hospital, Institution, or street address where death occurred: P. H. Hyatt.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED! (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury (If outside city or town limits write RURAL and give nearest town)

Street No. 309 Franklin Ave. (If rural, give LOCATION)

2.(a) If veteran, name war .....

3.(a) FULL NAME Henry Fulton Brewington

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Virginia Bowman Brewington

6.(c) If alive, give age 25 years

7. Birth date of deceased (mo., day, yr.) Aug. 1 1905

8. AGE: Years 41 | Months 1 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace Salisbury Md. (Town, county, and state)

10. Usual occupation Musician

11. Industry or business .....

MOTHER FATHER 12. Name Marion O. Brewington

13. Birthplace Salisbury Md.

MOTHER 14. Maiden name Margaret Fulton

15. Birthplace Fremont Md.

16. Informant Mrs. Virginia B. Brewington

Address 309 Franklin Ave. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept. 12-46 (month) (day) (year)

Cemetery or crematory Parsons Ave.

Location Salisbury Maryland.

18. Funeral director Tilghman & Co. Walter R. Tilghman

Address Salisbury Maryland

19. 9/12/46 Received by registrar Harriet E. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1946 at 6:10 a M

I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1946 to Sept 10 1946

and that I last saw him alive on Sept 9 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 day
Due to Diabetis Mellitus	20 yrs +
Due to HBP	2
	1
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. Wanner M. D.

M. D. or other

Address Salisbury Date signed 9/11/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

09396

Reg. Dist. No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 Years

Hospital, Institution, or street address where death occurred: 104 West Isabella St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 104 W. Isabella St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Fulton Brewington

3.(b) Social Security Number

4. Sex: Female

5. Color or race: white

6.(a) Single, Married, Widowed, or Divorced: widowed

6.(b) Name of husband or wife: Marion V. Brewington

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 9, 1867

8. AGE: Years 78 Months 10 Days 2 If less than one day ..... hrs. ..... min.

9. Birthplace: Snow Hill, Maryland. (town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Rev. Dr. Wm. S. Fulton

13. Birthplace: Scotland

MOTHER 14. Maiden name: Nancy Organ

15. Birthplace: Ohio

16. Informant: Lt. Cmda. Marion V. Brewington

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 14, 1946 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md.

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md

19. 9/20, 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 11, 1946 at 6 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19.. , to Sept 11 1946

and that I last saw h.. alive on Sept 10 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage, Recurrent	
Due to: Hypertensive Cardiovascular Disease	
Due to:	
Other conditions: Generalized Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: T. Rivers Hanson, M.D.

M. D. or Other

Address: Salisbury, Md Date signed 9/14/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

09397

Reg. Dist. No. 337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Bivalve, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Bivalve
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Raleigh Dunn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Victoria Dunn (don't know)

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 9, 1871

8. AGE: Years	Months	Days	If less than one day
75	7	17	..... hrs. ..... min.

9. Birthplace Bivalve, Wicomico, Md.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name William Dunn

13. Birthplace Jesterville, Md.

MOTHER 14. Maiden name Adeline Covington

15. Birthplace Jesterville, Md.

16. Informant Geo. W. F. Insley

Address Bivalve, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/29/46 (month) (day) (year)

Cemetery or crematory Cemetery — Insley

Location Bivalve, Md.

18. Funeral director C. E. Messick

Address Bivalve, Md.

19. Sep 29 1946 (Date rec'd by registrar) H. Wolford Dallas Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 26 1946, at 11.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1946 to Sept 26 1946 and that I last saw him alive on Sept 26 1946

Immediate cause of death	DURATION
Coronary occlusion	24 hrs
Due to Arteriosclerosis	2
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert Lore M.D.
M. D. or other

Address Hantsville Date signed 9-29-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

09398

CERTIFICATE OF DEATH

★ Reg. Dist. No. 337

1. PLACE OF DEATH:
County Wicomico
City or town Watervieew
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Watervieew
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME William Franklin Evans

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife Minnie H. Evans
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Oct. 11, 1869

8. AGE: Years	Months	Days	If less than one day
76	10	29	hrs. min.

9. Birthplace Watervieew, Wicomico, Md. (Town, county, and state)
10. Usual occupation Waterman
11. Industry or business

FATHER
12. Name Robert G. Evans
13. Birthplace Deals Island, Md.

MOTHER
14. Maiden name Sally Bradshaw
15. Birthplace Smiths Island, Md.

16. Informant Minnie G. Evans
Address Watervieew, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/12/46 (month) (day) (year)
Cemetery or crematory Turners Cemetery
Location Nanticoke, Md.
18. Funeral director C. G. Messick
Address Bivalve, Md.
19. Sept. 12 1946 (Date rec'd by registrar) R. Woolford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 10 1946, at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from medical examination
..... 19..... to ..... 19.....
and that I last saw ..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Hemorrhage	sudden death
Due to	
Due to	
Other conditions Previous cerebral hemorrhage	2 yrs

(Include pregnancy within 3 months of death)
Major findings of operations none
Date of op.
Autopsy results No
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. H. Lademacher M.D. Deputy Med. Examiner
M. D. or other
Address Salisbury Md Date signed 9/12/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

09399 ★ Reg. Diat. No. 333

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 5 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 1516 N. Division St. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME John W Grabiel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Margaret Grabiel
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Oct 22, 1889

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
56	11	5		

9. Birthplace Rushsylvania, Ohio (town, county, and state)
10. Usual occupation Retired
11. Industry or business

MOTHER FATHER
12. Name William H Grabiel
13. Birthplace Rushsylvania, Ohio
14. Maiden name Margaret Hopkins
15. Birthplace Sunbury, Ohio

16. Informant Mr Harry L Miller
Address Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 1, 1946 (month) (day) (year)
Cemetery or crematory Bellefontaine Cemetery
Location Bellefontaine Ohio
18. Funeral director The Hill & Johnson Co
Address Salisbury, Md

19. 9/28/46 (Date rec'd by registrar) Carrie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1946, at 2:15 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 24 1946, to Sept. 27 1946
and that I last saw him alive on Sept. 27, 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage, Recurrent	
Due to Hypertensive Cardio Vascular Renal Disease with Uremia	
Due to	
Other conditions Nephrosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations none
Date of op.
Autopsy results Confirmed Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Rivers Hanson M.D.
M. D. or other
Address Salisbury, Md Date signed 9/28/46

Evidence for change of age shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

FILM No. I 07 OCT 11 1946

CERTIFICATE OF DEATH

189400

Reg. Dist. No. 393

1. PLACE OF DEATH:

County Wicomico

City or town Tyaskin, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

P.G. Hospital — Salisbury, Md.

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Tyaskin

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward I. Hearn

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife Clara A. Hearn

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1867

8. AGE: Years	Months	Days	If less than one day
78 99	11	19	..... hrs. ..... min.

9. Birthplace Tyaskin, Wicomico, Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John A. S. Hearn

13. Birthplace Wetipquin, Md.

MOTHER 14. Maiden name Alice Battie

15. Birthplace Tyaskin, Md.

16. Informant Stanley Hearn

Address Tyaskin, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/14/46 (month) (day) (year)

Cemetery or crematory Tyaskin Church Cem.

Location Tyaskin

18. Funeral director C. E. Messick

Address Bivalve, Md.

19. 9/11 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1946, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-8-46 1946, to 9-11-46 1946 and that I last saw h. alive on 9-10-46 1946

Immediate cause of death	DURATION
Cardiac failure	
Due to Hypertensive Cardio Vascular disease	
Due to arteriosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert Stone M.D. M. D. or other

Address Fruitland Date signed 9-13-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

09401

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: Quantico md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 4 months
Hospital, institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Quantico md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Hallie Johnson

3.(b) Social Security Number: no

4. Sex: female
5. Color or race: a.a.
6.(a) Single, married, widowed, or divorced: widow
6.(b) Name of husband or wife: Edward Johnson
6.(c) If alive, give age: Died years
7. Birth date of deceased (mo., day, yr.): 1873
8. AGE: Years: 73 Months: Days: If less than one day: hrs. min.
9. Birthplace: Roanoke va (Town, county, and state)
10. Usual occupation: Housekeeping
11. Industry or business: Same as above
FATHER 12. Name: Frank Patten
FATHER 13. Birthplace: Roanoke va
MOTHER 14. Maiden name: Amelia Walker
MOTHER 15. Birthplace: Franklin va.
16. Informant: Kathrine Angulo
Address: Quantico Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4-46 (month) (day) (year)
Cemetery or crematory: Quantico
Location: Quantico md
18. Funeral director: James H. Stewart
Address: Salisbury Md
19. 9/4/46 Hallie E. Johnson Registrar
(Date rec'd by registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 2 1946 at 1:30 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7-16 1946 to Aug. 31 1946
and that I last saw h.. alive on Aug. 31 1946
Immediate cause of death: Coronary Occlusion — DURATION: 8-1-46
Due to: Contributory cause: Myocardial Damage — 4-16-46
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. A. Purnell, M.D. M. D. or other
Address: 800 Main St Quantico Date signed: 9-4-46

Dr. Rademacher

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (188)

09402

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Dela. County: Sussex
City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. R. 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Johnson Mr. Martin F.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	✓

6.(b) Name of husband or wife: Johnson Mrs. Rose
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Feby 8 1876

8. AGE: Years: 70 | Months: 7 | Days: 17 | If less than one day: ... hrs. ... min.

9. Birthplace: Delaware (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER — 12. Name: Josiah G. Johnson
13. Birthplace: Delaware
MOTHER — 14. Maiden name: Elenia Johnson
15. Birthplace: Delaware
16. Informant: Rose E. Johnson
Address: Laurel Del
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 27 1946 (month) (day) (year)
Cemetery or crematory: Old Zion Church Cemetery
Location: Farmington Delaware
18. Funeral director: J. Harvey Williamson
Address: Del. Salisbury Md.
19. 9/27/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 25 1946, at 7½ P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19...
and that I last saw him alive on ... 19... and that death occurred at ... M.

Immediate cause of death	DURATION
Intra cerebral Hemmorhage	9/14/46
Due to	
Due to: Lacerated left arm	9/14/46
Other conditions: Uremia — Acute nephritis	9/14/46

(Include pregnancy within 3 months of death)

Major findings of operations: Rt. Cerebral atrophy and Infarct from
Date of op. 9/25/46
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 9/14/46
Where did injury occur? Farm (City or town) Sussex (County) Del (State)
Injured at home, farm, industry, public place (where?) Farm
Means of injury: Gored by Bull Injured at work? Yes

23. SIGNATURE: J.A. Rademacher M.D.
Deputy Med. Examiner
M. D. or other
Address: Salisbury Md. Date signed: 9/25/46

VS A15 9-45-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

Reg. Dist. No. 0403333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 51 Years
Hospital, Institution, or street address where death occurred: 104 Winder
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 104 Winder
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Lucy A. Laws

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Married

6.(b) Name of husband or wife: Thomas Edward Laws
6.(c) If alive, give age: 86 years

7. Birth date of deceased (mo., day, yr.): March 16 1862

8. AGE: Years	Months	Days	If less than one day
84	5	26	hrs. min.

9. Birthplace: Wonga Wicomico Co. Md (Town, county, and state)
10. Usual occupation: At Home
11. Industry or business

FATHER
12. Name: William Twilley
13. Birthplace: Wonga Wicomico Co, Md

MOTHER
14. Maiden name: Mary White
15. Birthplace: Wonga Wicomico Co, Md

16. Informant: Wm. P. Laws
Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 13, 1946 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Md

18. Funeral director: The Hilbert Johnson
Address: Salisbury Md

19. 9/12/46 (Date rec'd by registrar) Harriet E. Johnson (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11 1946, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 46 to Sept 11 19 46
and that I last saw her alive on Sept 10 19 46

Immediate cause of death: Cerebral Hemorrhage 3 yrs.

DURATION

Due to:
Due to:
Other conditions: Hypertension
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard R. Mayer M. D. or other
Address: Salisbury Md Date signed: 9/12/46

Dr. Rademeke

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-2)

CERTIFICATE OF DEATH

09404

Reg. Diat. No. 223

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred: 498 Washington St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits write RURAL and give nearest town)
Street No.: 498 Washington St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clarence Edward Livingstone

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Henrietta P. Livingstone
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): March 15, 1871

8. AGE: Years 75 | Months 5 | Days 27 | If less than one day: hrs. min.

9. Birthplace: Salisbury Md.
(Town, county, and state)
10. Usual occupation: Shipping Clerk
11. Industry or business: Sawmill
12. FATHER Name: Peter Livingstone
13. FATHER Birthplace: Wico. Co. Md.
14. MOTHER Maiden name: Louisa Dixon
15. MOTHER Birthplace: Wico. Co. Md.
16. Informant: Mrs. Henrietta P. Livingstone
Address: 498 Washington St. Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 14-46 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.
19. 9/14/46 (Date received by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12th 1946 at 5 a.m. P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.... to ..... 19.... and that I last saw him alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary occlusion	Sudden death
Due to: Arteriosclerosis & Hypertension	3 yrs
Due to:	
Other conditions: Carcinoma of Penis.	3 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.
22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?
23. SIGNATURE: Lt Rademeke Deputy Medical Examiner M. D. or other
Address: Salisbury, Md. Date signed: 9/13/46

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

09405

CERTIFICATE OF DEATH

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city of town limits, write RURAL and give nearest town)

How long in above place of death? 67 Years

Hospital, institution, or street address where death occurred: 533 South Division St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 533 South Division St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: L. Merrill Morris

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: S. Martha Morris

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): July, 17, 1878

8. AGE: Years: 68 Months: I Days: I4 If less than one day: hrs. min.

9. Birthplace: Salisbury, Wicomico Co. Md (Town, county, and state)

10. Usual occupation: Lumber Mill

11. Industry or business: Owner

FATHER 12. Name: Thomas C. Morris

13. Birthplace: Wicomico Co. Md

MOTHER 14. Maiden name: Eliza C. Williams

15. Birthplace: Wicomico Co. Md

16. Informant: Mrs. L. Merrill Morris

Address: Salisbury, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4, 1946 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Md

18. Funeral director: The Hill & Johnson Co.

Address: Salisbury, Md

19. 9/9/46 (Date received by Registrar) Hazel E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 1, 1946 at 955P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19.. to Sept. 1 1946

and that I last saw him alive on Sept 1 1946

Immediate cause of death	DURATION
Coronary Occlusion	
Due to: Coronary Sclerosis	
Due to: Hypertensive Cardio-vascular	
Other conditions: Disease	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: T. Rives Hanson, M.D. M. D. or other

Address: Salisbury, Md Date signed: 9/4/46

Dr. Gray

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (100-)

CERTIFICATE OF DEATH

09406

Reg. Dist. No. 399

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. Route #3
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John Thomas Mumford

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Wid.

6.(b) Name of husband or wife: Lavenia J. Mumford
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): November 28, 1885

8. AGE: Years	Months	Days	If less than one day
60	9	24	...hrs. ...min.

9. Birthplace: Parsonsburg Md.
(Town, county, and state)

10. Usual occupation: Farmer and Chickens Grower
11. Industry or business: " " "

FATHER
12. Name: John Edward Mumford
13. Birthplace: Parsonsburg Md.

MOTHER
14. Maiden name: Gertie Parsons
15. Birthplace: Parsonsburg Md.

18. Informant: Mrs. Wilson Mrs Wilson Lingo
Address: Parsonsburg Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 7 1946 (Month) (Day) (Year)
Cemetery or crematory: Parsonsburg Church Cemetery
Location: Parsonsburg Maryland

18. Funeral director: Holloway & Co Per. Preston Holloway
Address: 520 E. Church St. Salisbury Md.

19. 9/6/1946 (Date rec'd by registrar) Harriet D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 4 th. 1946 at 9.10 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 31 1946 to Sept 4 1946 and that I last saw him alive on Sept. 4 1946

Immediate cause of death	DURATION
Pulmonary embolism	
Due to Thrombophlebitis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. M. Gray M.D. M. D. or other
Address: Salisbury Md. Date signed: 9/6/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (130)

CERTIFICATE OF DEATH

69407

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Md R.F.D. No 1

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 4 days

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? four days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico

City or town Salisbury Md R.F.D.

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Ethell Narine

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	Single.

6.(b) Name of husband or wife no

6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) Aug 1 1936

8. AGE: Years 10 Months 1 Days 11 If less than one day ..... hrs. ..... min.

9. Birthplace Salisbury Md (Town, county and state)

10. Usual occupation School Girl

11. Industry or business Same as above

MOTHER FATHER

12. Name unknown

13. Birthplace unknown

MOTHER

14. Maiden name Ethell Perrine

15. Birthplace Salisbury Md

16. Informant Margaret Thader

Address Salisbury Md

17. Burial (Burial, cremation, or removal. Which) Date thereof Sept 25 1946 (month) (day) (year)

Cemetery or crematory Mt Calvary

Location Parsonsburg Md

18. Funeral director James R Stewart

Address Salisbury Md

19. 9/26 1946 Harriet E Johnson Registrar

(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 21 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 18 1946 to Sept 21 1946 and that I last saw h[illegible] alive on Sept 21 1946

Immediate cause of death	DURATION
Acute Bright's Disease	10 dys
Due to uremia no.	
Due to Kidney of pregnancy deceased	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Thos R Mann M. D. or other

Address Salisbury Md Date signed 9/22/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

09408

Reg. Diat. No. 17 336

1. PLACE OF DEATH:

County: Wicomico

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 70 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar

(If outside city or town limits, write RURAL and give nearest town)

Street No. 424 East

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Thomas Edward Parker

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maggie Parker

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Oct-1-1875

8. AGE:

Years	Months	Days	If less than one day
70			....hrs. ....min.

9. Birthplace: Wicomico, Maryland (Town, county, and ~~state~~)

10. Usual occupation: Retired Machinist

11. Industry or business: Railroad

FATHER

12. Name: Scott Parker

13. Birthplace: Wicomico County, Md.

MOTHER

14. Maiden name: Eliza Hastings

15. Birthplace: Sussex county, Del.

16. Informant: Maggie Parker

Address: Delmar, Delaware

17. Burial — Date thereof: 9-25-46 (month) (day) (year)

(Burial, ~~cremation, or removal~~. Which?)

Cemetery ~~or crematory~~: M. E.

Location: Delmar, Delaware

18. Funeral director: W. S. Mansel Co

Address: Delmar, Delaware

19. 9-24 1946 Harry E. Hudson

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 23 1946, at 2:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 23 1946 to Sept 23 1946 and that I last saw h— alive on Sept 23 1946

Immediate cause of death	DURATION
Acute Coronary Thrombosis	
Due to Arterio Sclerosis & attack of myocardium	1 year 2 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. H. Lynch M. D. or other

Address: Delmar Del. Date signed: Sept 23/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-43-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (184)

CERTIFICATE OF DEATH

Reg. Dist. No. 0940 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH

County: Wicomico

City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred: Elizabeth St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No.: Elizabeth St (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME Parsons, Elwood Daniel

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 30, 1941

8. AGE: Years	Months	Days	If less than one day
4	10	18	hrs. min.

9. Birthplace: Salisbury, Wicomico Co, Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business

MOTHER FATHER

12. Name: James L. Parsons

13. Birthplace: Wicomico Co, Md

14. Maiden name: Helen Jones

15. Birthplace: Wicomico Co, Md

16. Informant: Mr James L. Parsons

Address: Delmar Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 20, 1946 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury Md

18. Funeral director: The Hill & Johnson

Address: Salisbury, Md

19. 9/20, 1946. Harriet E. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/17 1946, at 12:30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from died on 1946

and that I last saw h alive on 1946

Immediate cause of death: Bullet wound of brain — DURATION: sudden death

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 9/17/46

Where did injury occur? Delmar (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Unloaded 22 gun fired by brother Injured at work? No

23. SIGNATURE: J.A. Redemaker M.D. Deputy medical examiner M. D., or other

Address: Salisbury Md Date signed: 9/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

09410

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 years
Hospital, institution, or street address where death occurred 616 Naylor street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 616 Naylor st. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sallie Polk

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Charles J. Polk
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): April 28-1865

8. AGE: Years 81 Months 4 Days 29 If less than one day hrs. min.

9. Birthplace: R.D. Salisbury Md. (Town, county, and state)
10. Usual occupation: at Home
11. Industry or business
12. Name of FATHER: Johnathan Hastings
13. Birthplace of FATHER: Wicomico C. Md.
14. Maiden name of MOTHER: Lottie Calloway
15. Birthplace of MOTHER: Wicomico C. Md.
16. Informant: Mrs. Sallie Parker
Address: 616 Naylor st. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 29-46 (month) (day) (year)
Cemetery or crematory: Mt Zion Cem.
Location: R.D. Laurel Delaware
18. Funeral director: Holloway & G. Walter R. Holloway
Address: Salisbury Md.
19. 9/28/46 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 27 19 46 at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19 to Sept 27 19 46 and that I last saw her alive on Sept 25 19
Immediate cause of death: Chronic nephritis — DURATION 4 yrs +
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Nature of injury: Injured at work?

23. SIGNATURE: W. Parramore M.D. M. D. or other
Address: Salisbury Date signed: Sept 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

09411

CERTIFICATE OF DEATH

Reg. Dist. No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Four months

Hospital, Institution, or street address where death occurred: Peninsula Gen Hospital

How long in hospital or institution? Four months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury md (If outside city or town limits, write RURAL and give nearest town)

Street No.: Pillats Alley (If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Rosa Pumell

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	A.A.	Married

6.(b) Name of husband or wife: James E Pumell

6.(c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): about 1879

8. AGE: Years: 67 about; Months; Days; If less than one day: hrs. min.

9. Birthplace: Parsonsburg md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same as above

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Emeline Parker

MOTHER — 15. Birthplace: Parsonsburg md

16. Informant: Elizabeth Shockley

Address: Salisbury md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 18-46 (month) (day) (year)

Cemetery or crematory: Hamilton

Location: Salisbury Md

18. Funeral director: James H Stewart

Address: Salisbury md

19. 9/18, 1946 (Date received by registrar) Harriet E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 18 1946 at 5:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-2 1946 to 9/15 1946 and that I last saw her alive on 9/14 1946

Immediate cause of death: Recurrent Cerebral hemorrhage — DURATION:

Due to: Hypertensive Cardio-Vascular disease

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Oliver Hanson M.D. M.D. or other

Address: Salisbury, Md Date signed: 9/15/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (67)

CERTIFICATE OF DEATH

09412

Reg. Diat. No. 3335

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Wicomico.
City or town Sharptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war no

3.(a) FULL NAME Rogers, Hobart

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married.

6.(b) Name of husband or wife Armenia
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1896

8. AGE: Years	Months	Days	If less than one day
49	11	10	..... hrs. ..... min.

9. Birthplace Georgetown, Sussex Co., Del.
(Town, county, and state)
10. Usual occupation Lumberman
11. Industry or business Lumber. Mill.
FATHER 12. Name Albert Rogers.
13. Birthplace Delaware.
MOTHER 14. Maiden name Emma Littleton
15. Birthplace Delaware.
16. Informant Mrs. Armenia Rogers (Armenia Rogers)
Address Sharptown, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 8 1946 (month) (day) (year)
Cemetery or crematory The Union Cemetery
Location Georgetown, Del.
18. Funeral director Graves & Bros.
Address Georgetown, Del. Sharptown Md
19. Sept 7 1946 (Date rec'd by registrar) Walter G. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 5 19 46 at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 to Sept 5 19
and that I last saw deceased alive on Sept 5 19
Immediate cause of death Hemorrhage — DURATION 15 minutes
Due to Stab wound of left chest — 15 mins.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operation None
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Homicide Date of 9/5/46
Where did injury occur? Sharptown (City or town) Wicomico (County) Md. (State)
Injured at home, farm, industry, public place (where?) Eatery Sharptown
Means of injury Stabbed with bayonet Injured at work? No

23. SIGNATURE Deputy Med Examiner M. D. or other
Address Salisbury, Md. Date signed 9/7/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

CERTIFICATE OF DEATH

09413

Reg. Dist. No. 993

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. R 7 D
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Shockley, Mr. John

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Lula Shockley

6.(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) Jan 28 - 1890

8. AGE: Years 56 | Months 7 | Days 29 | If less than one day ... hrs. ... min.

9. Birthplace Wicomico County, Md
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business Farm

FATHER 12. Name Dayton S. Shockley

13. Birthplace Wicomico County, Md.

MOTHER 14. Maiden name Annie Dorsey

15. Birthplace Wicomico County, Md

16. Informant Lula Shockley

Address Salisbury, Md

17. Burial Date thereof Sept 29 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or ~~crematory~~ Parkside

Location Salisbury Md

18. Funeral director W. S. Ingram Co

Address Salisbury, Md.

19. 9/29/46 H. Harris E. Johnson Salisbury
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 27 1946, at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 25 1946 to Sept 27 1946 and that I last saw him alive on Sept 26 1946

Immediate cause of death	DURATION
Pneumonia	1 day
Due to	
Due to Arteriosclerosis	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE J. Brasure M.D.
M. D. or other

Address Salisbury Date signed Sept 27

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

09414

CERTIFICATE OF DEATH

Reg. Dist. No. 383

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred: 105 Evans St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 105 Evans St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: William Carl Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Sarah E. Smith
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): Aug. 16-1885

8. AGE: Years: 61 Months: 0 Days: 27 If less than one day: hrs. min.

9. Birthplace: Salisbury Md.
(Town, county, and state)
10. Usual occupation: attendant at
11. Industry or business: filling station
FATHER 12. Name: Somerset L. Smith
13. Birthplace: Wic. Co. Md.
MOTHER 14. Maiden name: Amanda Riggin
15. Birthplace: Wic. Co. Md.
16. Informant: Mrs. Sarah E. Smith
Address: 105 Evans St. Salisbury Md
17. Burial, cremation, or removal (which?) Burial Date thereof: Sept. 16-46 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md
18. Funeral director: Holloway & Wells R. Holloway
Address: Salisbury Md.
19. 9/16/46 Harriet L. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13th 1946 at 12:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1946 to Sept 13 1946 and that I last saw him alive on Sept 11 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 yr.
Due to: Hypertension	4 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lester R. Mann M. D. or other
Address: Salisbury Md Date signed: 9/13/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

09415 999

Reg. Dist. No.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(I)

VS A15 9-45-15

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 days

Hospital, Institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 34 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No. State (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Townsend, Shirley Ann

3.(b) Social Security Number 221-12-8941

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Feb 1-1924

8. AGE: Years 22 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Milton, Del. (Town, county, and state)

10. Usual occupation Teacher

11. Industry or business High School

FATHER 12. Name John G. Townsend

13. Birthplace Brookville, Md.

MOTHER 14. Maiden name Lillah Munro

15. Birthplace Baltimore, Md.

16. Informant J. G. Townsend

Address Delmar, Del.

17. Burial, cremation, or removal. Which? Burial Date thereof Oct 2-1946 (month) (day) (year)

Cemetery or crematory Fruitland Cemetery

Location Delmar, Del

16. Funeral director W. S. Harvel Co.

Address Delmar, Delaware

19. (Date rec'd by registrar) 10/2, 1946 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1946, at 2:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-26 1946 to 9-29 1946 and that I last saw h alive on Sept 29 1946

Immediate cause of death	DURATION
Typhoid Fever	May
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Salisbury Date signed 9/30/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09416

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State: Md. County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Southey S. Truitt

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Smith Truitt
6.(c) If alive, give age: 50 years
7. Birth date of deceased (mo., day, yr.): Dec. 12 1885

8. AGE: Years	Months	Days	If less than one day
60	9	7	hrs. min.

9. Birthplace: R.D. Pittsville Md (Town, county, and state)
10. Usual occupation: merchant
11. Industry or business:

FATHER 12. Name	Greenbury Truitt
FATHER 13. Birthplace	R.D. Pittsville Md
MOTHER 14. Maiden name	Hannah White
MOTHER 15. Birthplace	Pittsville Delaware

16. Informant: Mrs. Anna S. Truitt
Address: Pittsville Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 11 1946 (month) (day) (year)
Cemetery or crematory: Evergreen Cem.
Location: Berlin Maryland
18. Funeral director: Holloway & Gordy
Address: Salisbury Md
19. 9/11 1946 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 8 1946 at 7 a. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 to day of death 1946 and that I last saw h alive on 9-8-46 1946

Immediate cause of death	DURATION
Coronary Thrombosis.	
Due to	
Due to	
Other conditions: Hypertension Myocardial infarct in 1942	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank R. Lewis M.D. M. D. or other
Address: Salisbury Md Date signed: 9-8-46

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 37-D

CERTIFICATE OF DEATH

09417

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
P. G. Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Jesterville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles F. Turner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Col.	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Nov. 23, 1923

8. AGE: Years: 23 | Months: 9 | Days: 22 | If less than one day: ... hrs. ... min.

9. Birthplace: Jesterville, Wicomico, Md.
(Town, county and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Robert Turner
13. Birthplace: Jesterville, Md.

MOTHER — 14. Maiden name: Sidney Turner
15. Birthplace: Jesterville, Md.

16. Informant: Robert Turner
Address: Jesterville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/19/46 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Jesterville, Md.

18. Funeral director: C. S. Messick

Address: Byrdale, Md.

19. 9/18 19 46 (Date received by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 15 19 46 at 6:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-8-46 19 ... to 9-15-46 19 ... and that I last saw h. alive on 9-15-46 19 ...

Immediate cause of death	DURATION
Pulmonary Edema	2 hrs.
Due to: Virus Encephalitis	3 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. J. Roe M.D.
M. D. or other

Address: Pantridge Md. Date signed: 9-16-46

9450

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186a

CERTIFICATE OF DEATH

Reg. Dist. No. 999

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred: R.D. #2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new born infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME William Fred Twilley — 3. (b) Social Security Number

4. Sex: Male | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Nannie M. Twilley — 6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) Sept. 18- 1860

8. AGE: Years 86 | Months 0 | Days 5 | If less than one day: hrs. min.

9. Birthplace Somerset Co. Md. (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER
12. Name Rev. Washington Twilley
13. Birthplace Princess Md.

MOTHER
14. Maiden name Caroline Taylor
15. Birthplace Princess Md.

16. Informant Mr. Norman Twilley
Address R.D. #2. Salisbury Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof Sept. 25-46 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Maryland

18. Funeral director Holloway & Co. Walter R. Holloway
Address Salisbury Maryland.

19. 1/14/47 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1946 at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... and that I last saw him alive on ... 19 ... and that death occurred at ... M.

Immediate cause of death: Fractured left hip — DURATION
Brain concussion.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident — Date of 9/13/46
Where did injury occur? Helmar (City or town) Wicomico (County) Md. (State)
Injured at home, farm, industry, public place (where?) Farm
Means of injury: Fell down — Injured at work? No

23. SIGNATURE Jas Calendine M.D. Deputy medical Examiner
M. D. or other
Address Salisbury, Md. Date signed 9/24/46

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

09418 ★ Reg. Dist. No. 999

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Worcester
City or town Berlin
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Tyndall

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

B.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1946

8. AGE: Years | Months | Days | If less than one day: 7 hrs. 30 min.

9. Birthplace Salisbury-Wicomico, Maryland (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Tyndall Mr. Ernest Jackson

13. Birthplace Salisbury-Maryland

MOTHER 14. Maiden name Buttingham Dorothy

15. Birthplace Morristown Penn

16. Informant

Address

17. (Burial, cremation, or removal. Which?) Date thereof (mooth) (day) (year)

~~Cemetery~~ or crematory Commander General Lapsley

Location Salisbury, Maryland

18. Funeral director

Address

19. 9/26, 1946 Harriet E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

23. DATE OF DEATH September 22 1946 at 10 15 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 to 19

and that I last saw h alive on 19

Immediate cause of death — DURATION

Prematurity - 6 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Fred R. Graves M.D.
M. D. or other

Address Salisbury, Md. Date signed 9-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09419

★ Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No. 305 Front Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Alice Vincent

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: William H. Vincent

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 13, 1881

8. AGE:

Years	Months	Days	If less than one day
65	6	22	..... hrs. ..... min.

9. Birthplace: Sussex County, Delaware
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER
12. Name: George Hall
13. Birthplace: Sussex County, Delaware

MOTHER
14. Maiden name: Nancy —
15. Birthplace: Sussex County, Delaware

16. Informant: Viola B. West

Address: Laurel, Delaware R.F.D. #1 Box 137

17. Burial (Burial, cremation, or removal. Which?) Date thereof September 9 1946 (month) (day) (year)

Cemetery or crematory: Rose Point Cemetery

Location: Near Laurel, Delaware

18. Funeral director: J. T. Frampton and Son

Address: Fedelalsburg, Maryland

19. 9/7 (Date rec'd by registrar) 19 46 Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5, 1946, at 8 35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/1 1946 to 9/5 1946

and that I last saw h.. alive on 9/5 1946

Immediate cause of death	DURATION
pulmonary embolus	5 min.
Due to thrombophlebitis	1 wk
left leg.	
Due to	
Other conditions diabetes, severe tuberculosis, pulmonary	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: see above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Charles M. Moyer M. D. or other

Address: Laurel Hd Date signed: 9/9/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Mr. Berger

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09420

CERTIFICATE OF DEATH

Reg. Dist. No. 933

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 10/31/45
Hospital, Institution, or street address where death occurred:
Eastern Shore Tuberculosis Sanatorium
How long in hospital or institution? Since 10/31/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Fruitland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: WALTERS, William Harold

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elsie Walters
6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): Jan. 1, 1915

8. AGE: Years	Months	Days	If less than one day
31	8	28	hrs. min.

9. Birthplace: Deals Island, Maryland
(Town, county, and state)
10. Usual occupation: Mechanic
11. Industry or business

FATHER
12. Name: Willie Walters
13. Birthplace: Maryland

MOTHER
14. Maiden name: Addie Bedsworth
15. Birthplace: Oriole, Maryland

16. Informant: self
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 2-1946 (month) (day) (year)
Cemetery or crematory: Oriole Cem.
Location: Oriole Maryland.

18. Funeral director: L.B. Webster
Address: Deal Island Maryland

19. 9/30 1946 (Date received by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 29 1946 at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 31, 1945 to Sept. 29 1946 and that I last saw him alive on Sept. 28 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	14 month
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Paul [illegible] M. D. or other
Address: Snow Hill, Md. Date signed: 9/30/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 57-a

CERTIFICATE OF DEATH

★ 09421

Reg. Dist. No. 337

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The exact age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Watertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residance of mother)

State Md. County Wicomico

City or town Watertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lynn Ward Webster

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 7, 1928

8. AGE:

Years	Months	Days	If less than one day
17	11	7	..... hrs. ..... min.

9. Birthplace Watertown, Wicomico, Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name James Webster

13. Birthplace Sandy Island, Md.

MOTHER

14. Maiden name Ella Dunn

15. Birthplace Bivalve, Md

16. Informant Doris Webster

Address Watertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/18/46 (month) (day) (year)

Cemetery or crematory Cemetery, Funeral

Location Nanticoke, Md.

18. Funeral director C. G. Messick

Address Bivalve, Md.

19. Sept. 18 1946 (Date rec'd by registrar) Mr. P. Woodford Webster Registrar Nanticoke, Md.

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 15 1946, at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 5 '46 1946, to Sept 15 1946

and that I last saw h[illegible] alive on July 5th 1946

Immediate cause of death ..... DURATION

acute Gastric dilatation ..... 3 Days

Due to Still's disease 2

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Robert Stone M.D. M. D. or other

Address Nanticoke, Md. Date signed 9-16-46

Dr. Long

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

09422

CERTIFICATE OF DEATH ★

Reg. Dist. No. 923

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: P.S. Hoyt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md. County: Wicomico
City or town: Parsonsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: RD. #2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Fannie Catherine Wells

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Elijah H. Wells
6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): March 20-1877

8. AGE: Years: 69 | Months: 5 | Days: 19 | If less than one day: hrs. min.

9. Birthplace: RD Salisbury Md.
(Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER
12. Name: John Elliott
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Mary Taylor
15. Birthplace: Sussex Co. Delaware

16. Informant: Mrs. Elsie H. Wells
Address: 504 Mitchell St. Salisbury Md.

17. Burial (Burial, cremation, or removal): Date thereof: Sept. 11 (month) (day) 1946 (year)
Cemetery or crematory: Pittsville Cem.
Location: Pittsville Maryland

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Maryland

19. 9/11 1946 (Date rec'd by Registrar) Harriet D. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9 1946 at 11 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8, 1946 to Sept 9, 1946 and that I last saw h[illegible]R alive on Sept 9, 1946

Immediate cause of death	DURATION
Cardiac failure	12 hrs.
Due to: thyroid crisis.	4-6 days
Due to: thyrotoxicosis	5-6 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William B. Long M.D.
M. D. or coroner
Address: 504 W. Division St Salisbury, Md. Date signed: 9/10/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

09423

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomoco
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
415 Davis St.
How long in hospital or institution? –

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomoco
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 415 Davis St.
(If rural, give LOCATION)
2.(a) If veteran, name war –

3.(a) FULL NAME Annie Willey

3.(b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife –
6.(c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) 1874

8. AGE: Years	Months	Days	If less than one day
72	–	–	...hrs. ...min.

9. Birthplace Salem, Dor. Co., Md.
(Town, county, and state)

10. Usual occupation –

11. Industry or business –

FATHER
12. Name Not Known
13. Birthplace " "

MOTHER
14. Maiden name Not Known
15. Birthplace " "

16. Informant Miss Mable Marshall
Address Willis St., Cambridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15, 1946 (month) (day) (year)
Cemetery or crematory Cambridge Cemetery
Location Cambridge, Maryland

18. Funeral director The Hill & Johnson Co.
Address Salisbury, Maryland.

19. 9/28/46 (Date rec'd by registrar) Hazard L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 12 1946 at 8:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Aug 10 1946 to Sept 12 1946
and that I last saw h.e.r. alive on Sept 12 1946

Immediate cause of death Cerebral Hemorrhage — DURATION 12 hr
Due to Arteriosclerosis — 3
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert J. Gore M. D. or other
Address Salisbury, Maryland Date signed 9/19/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

M

The correct age is especially important. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-D

09425

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 64 Yrs
Hospital, Institution, or street address where death occurred: 132 Cherry St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Hebron Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Annie Mae Wilson
3.(b) Social Security Number

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife James W. Wilson
6.(c) If alive, give age ...... years
7. Birth date of deceased (mo., day, yr.) Jan. 4 1873
8. AGE: Years 73 Months 8 Days 21 If less than one day ...... hrs. ...... min.
9. Birthplace Wicomico, Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Alexander Collins
13. Birthplace Wicomico Md.
MOTHER 14. Maiden name Annie Wilson
15. Birthplace Wicomico Md.
16. Informant Roy Wilson
Address Hebron Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/28/46 (month) (day) (year)
Cemetery or crematory Wicomico Memorial Park
Location Salisbury Md.
18. Funeral director David H. Mesick
Address Hebron, Md.
19. 9/28 1946 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 25 1946, at 10:30 P M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1946, to Sept 25 1946
and that I last saw her alive on Sept 25 1946

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ...... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ...... Injured at work?

23. SIGNATURE L. R. Grume M.D. (M. D. or other)
Address Salisbury Md. Date signed 9-25-46

Dr. Nock

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

(52) 11424

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days 19 hrs.

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution? 9 days 19 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Rural Pocomoke
(If outside city or town limits, write RURAL and give nearest town)

Street No. ...
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Wilson, Frank

3.(b) Social Security Number 213-05-7058

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife Dola Wilson

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Dec 24, 1899

8. AGE:

Years	Months	Days	If less than one day
46	8	24	...hrs. ...min.

9. Birthplace Rural Pocomoke Somerset Md.
(Town, county, and state)

10. Usual occupation Day labor at Pilgrim

11. Industry or business Fertilizer plant

FATHER 12. Name Edwin Wilson

13. Birthplace Maryland

MOTHER 14. Maiden name Susan Harris

15. Birthplace Maryland

16. Informant Jessie Wilson

Address Rural Pocomoke Md.

17. Burial Date thereof Sept 18-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Unionville Cemetery

Location Rural Pocomoke Md.

18. Funeral director Henry R. Watson

Address Pocomoke Md.

19. 9/18 1946 Harriet E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 15 1946, at 12:45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/5 1946 to 9/15 1946 and that I last saw h... alive on 9/15 1946

Immediate cause of death	DURATION
Acute Appendicitis	4 hrs
Due to Obstruction of Heart	hrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Acute Appendicitis

Date of op. 9/15/46

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE ... M. D. or other

Address ... Date signed 9/15/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-6)

09426

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, Institution, or street address where death occurred:
Peninsula Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: 473 Lake St. Salisbury Md. (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Annie Mae Winder

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Single

6.(b) Name of husband or wife: none
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 22, 1907

8. AGE: Years: 39 | Months: 3 | Days: 25 | If less than one day: hrs. min.

9. Birthplace: Dunkirk, Wicomico, Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Daniel Winder
13. Birthplace: Dunkirk, Md.

MOTHER
14. Maiden name: Lucy Jones
15. Birthplace: Tennessee

16. Informant: Ella Purnell
Address: 10 Sunset Ave, Brownsville N.Y.

17. Burial, cremation, or removal. Which? Burial Date thereof (month) (day) (year): 9/19/46

Cemetery or crematory: Dunkirk Cem.
Location: Dunkirk Md.

18. Funeral director: David E. Messick
Address: Hebron, Md.

19. (Date rec'd by registrar) 9/19 19 46. Registrar: Harriet E. Johnson Local

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 16 1946, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1946 to Sept 16 1946 and that I last saw h... alive on Sept 15 1946

Immediate cause of death	DURATION
Rheumatic heart disease	7
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D.
M. D. or other
Address: Salisbury Md. Date signed: Sept 16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

CERTIFICATE OF DEATH

09427

Reg. Dist. No. 999

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Peninsula General

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Somerset

City or town Eden

(If outside city or town limits, write RURAL and give nearest town)

Street No. ✓

(If rural, give LOCATION)

2.(a) If veteran, name war ✓ 218-24-7313

3. (a) FULL NAME Wright, Beatrice

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a a	single

B.(b) Name of husband or wife ✓

B.(c) If alive, give age ✓ years

7. Birth date of deceased (mo., day, yr.) 8-22-'29

8. AGE: Years 17 | Months 1 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace Salisbury, Md. (Town, county, and state)

10. Usual occupation Factory Worker

11. Industry or business Dulany Johns

FATHER 12. Name John Wright

13. Birthplace Eden, Maryland

MOTHER 14. Maiden name Annie Smith

15. Birthplace Matchapongo, Virginia

16. Informant Mrs. Annie Wright

Address Fruitland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 10-3-46 (month) (day) (year)

Cemetery or crematory Eden Cemetery

Location Eden, Maryland

18. Funeral director James F. Stewart

Address 402 E. Church St. Salisbury Md

19. (Date rec'd by registrar) 10/3 19 46 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-28 19 46 at 7 05 P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from ..... to ..... 19..... and that I last saw h.... alive on ..... 19.....

Immediate cause of death	DURATION
Fractured skull	10 hrs.
Brain Injury	
Due to	
Due to	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations None Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 9/27/46

Where did injury occur? Fruitland (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Run over by car as pedestrian Injured at work? No

23. SIGNATURE J. S. Robinson M. D. (Physician, Nurse, C. E., or Other)

Address Salisbury Md Date signed 9/28/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-L)

CERTIFICATE OF DEATH

09428

Reg. Dist. No. 339

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days 5 hrs 55 Mins

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 8 days 5 hrs 55 Mins

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)

Street No. R 7 D (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Zollner, Mr. Adolph

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Widowed

6.(b) Name of husband or wife: Josephine Zollner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 11 - 1867

8. AGE: Years 79 | Months 3 | Days 4 | If less than one day ..... hrs. ..... min.

9. Birthplace: Denmark (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

MOTHER FATHER 12. Name: unknown

13. Birthplace: unknown

MOTHER 14. Maiden name: unknown

15. Birthplace: unknown

16. Informant: Robert Christopherson

Address: Delmar, Del

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 18 - 46 (month) (day) (year)

Cemetery or crematory: Odd Fellows

Location: Laurel, Del.

18. Funeral director: W. S. Mapp Co

Address: Delmar, Del

19. 9/18/46 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 15 1946, at 4:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/7 1946, to 9-15 1946 and that I last saw h.km alive on 9-15-46 1946

Immediate cause of death	DURATION
Uremia	
Due to: Prostatic hypertrophy	
Due to: And chronic Nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Chas G Lowber M. D. or other

Address: Salisbury Md. Date signed: 9-15-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15